STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING _____ B. WING _____	03/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGOLAND CHRISTIAN VILLAGE	6685 E 117TH AVE CROWN POINT, IN46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/21/11 Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Chicagoland Christian Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This facility was located on the west side of the first floor and the entire lower level of a two story	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	building. The facility surveyed as two separate buildings due to the addition of 8 beds in 2005. Building 1 was built prior to March 1, 2003, therefore it was surveyed in accordance with LSC Chapter 19. Building 3 was determined to be of Type II (111) construction, fully sprinklered, and consisted of 8 additional rooms (251-258) on the first floor surveyed in accordance with LSC Chapter 18. The facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and resident rooms. The facility has the capacity for 144 and had a census of 129 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/24/11. The facility was found not in compliance with the aforementioned requirements as evidenced by:			

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K0018 SS=E	Based on observation and interview, the facility failed to ensure there were no impediments to closing and latching doors protecting a corridor opening in 1 of 10 smoke compartments. This deficient practice affects staff, visitors and 14 residents in the Reclaim I smoke compartment. Findings include: Based on observation with the maintenance director on 03/21/11 at 4:10 p.m., the corridor door to the Social Services Director's office was held wide open with a door stop. When the doorstop was removed, the door failed to latch. Upon closer inspection by the maintenance director at the time of observation, a magnet was found to prevent the latch from engaging. The maintenance director agreed at the time of observations, the door mechanism should not have been tampered with. 3.1-19(b)	K0018	K 018 E1. What is the corrective action taken for the resident found to be affected by the deficient practice?The Social Service Director office door has been repaired enabling the latch of the door to engage. Social Service has bee nreinstructed to keep the door close. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All corridor doors in facility will be inspected by the maintenance department to ensure proper door closure. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur. A. Maintenance Supervisor and other facility staff will be re-inserviced on the proper door closer and the procedure for reporting concerns to the maintenace department. B. Proper door closures will be addressed immediately as they occurred and recorded on maintenance report log that it has been corrective or repaired. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place Maintenance staff will conduct random corridor checks one door per hallway per month and these checks will be reviewed by	04/20/2011

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			the maintenance supervisor and forwarded to the Administrator /Designee. The Administrator /Designee will report findings to Q/A committee .This will be ongoing as a component of the preventative maintenance program.	

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K0029 SS=E	Based on observation and interview, the facility failed to ensure hazardous areas in 3 of 8 smoke compartments such as soiled linen receptacles of more than 32 gallons within a 64 square foot area were located in a room equipped with self closing doors. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice affects all visitors staff and 68 residents in the Reclaim II, Haven, and Lower D smoke compartments. Findings include: Based on observations with the maintenance director on 03/21/11 between 12:05 p.m. and 12:55 p.m., the Reclaim II exit corridor was used as a collection point for two laundry barrels with a 32 gallon capacity. The equipment remained in place on 03/21/11 at 4:10 p.m., the Haven unit exit corridor was used as a collection point for four laundry barrels; four laundry barrels were located in the	K0029	K 00291. What is the corrective action taken for the resident found to be affected by the deficient practice? Reclaim 2, Haven and Edens D hall barrels were moved at the time that maintenance supervisor was made aware and staff was informed that if laundry barrels are not in use they need to be stored. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. At the time of finding staff were informed of the acceptable practice of moving the laundry barrels on all units. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur. Staff will be re-inservice on proper useage of laundry barrels and storage. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place. Maintenance staff while performing daily rounds will document laundry barrel useage and report findings to Maintenance Supervisor /Designee who will track findings. Maintenance Supervisor will report finding to Administrator /Designee who will report findings to Q/A monthly for six month.	04/20/2011

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	Lower D corridor. The barrels each had a capacity for 32 gallons which was confirmed with the maintenance director at the times of observation. 3.1-19(b)			

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K0038 SS=E	Based on observation and interview, the facility failed to ensure egress exit corridors in 3 of 8 smoke compartments were not used for storage. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1, "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects all visitors staff and 68 residents in the Reclaim II, Haven, and Lower D smoke compartments. Findings include: Based on observations with the maintenance director on 03/21/11 between 12:20 p.m. and 5:00 p.m., the Reclaim II exit corridor egress path was used as a collection point for two laundry barrels, a Hoyer lift and linen cart. The equipment remained in place on 03/21/11 at 4:10 p.m. The Haven unit exit corridor egress path was used as a collection	K0038	F 00381. What is the corrective action taken for the resident found to be affected by the deficient practice? Reclaim 2, Haven and Edens D hall barrels were moved at the time that maintenance supervisor was made aware and staff was informed that if laundry barrels are not in use they need to be stored. Hoyer lift and linen cart in reclaim 2 was removed at the time of observation. Haven hoyer lift and wheelchair were relocated at time of observation . Eden D hall gerri-chair , 4 laundry barrels ,hoyer lift and a bag of trash were removed at time of observation. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. At the time of the findings staff was informed of the acceptable practice of moving the laundry barrels ,resident equipment and trash . 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur. Staff will be re-inservice on proper useage of laundry barrels,resident equipment and trash which will include storage of laundry barrels,resident equipment and trash storage. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur	04/20/2011

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	point for four laundry barrels, a Hoyer lift and a wheel chair. At 4:15 p.m. on 03/21/11, there was no change in the equipment in the corridor. Four laundry barrels, three geri chairs and a Hoyer were located in the Lower D corridor. At 5:00 p.m. on 03/21/11, a bag of trash was added to the equipment stored in the corridor. The maintenance director said at the times of observation, staff were aware the corridors should be free of equipment not in use. 3.1-(19)		i.e. what quality assurance will be put in place. Maintenance staff while performing daily rounds will document laundry barrel resident equipment and trash useage and report findings to Maintenance Supervisor /Designee who will track findings. Maintenance Supervisor will report finding to Administrator /Designee who will report findings to Q/A monthly for six month.	

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K0050 SS=C	1. Based on record review and interview, the facility failed to ensure all elements of fire drills were included on documentation of fire drills for 2 of the past 4 quarters including the time the drill was conducted. This deficient practice affects all occupants. Findings include: Based on a review of Monthly Fire Drill(s) for the past year with the maintenance director on 03/21/11 at 1:15 p.m., fire drill documentation did not include the actual time of the drill. The time of each drill was noted as 7-3, 3-11, or 11-7 on the record during the third and fourth quarters of 2010. The maintenance director said at the time of record review, he was unaware the specific times fire drills were conducted should also be included in the documentation. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to conduct fire drills at varied times	K0050	k 00501. What is the corrective action taken for the resident found to be affected by the deficient practice? A.We cannot correct the actual time of the fire drill docuemntation but in the furture times will be documeted . B. We cannot correct the times that fire drill were held but in the future we will conduct fire drills at various time and shifts. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected by deficient practice. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur. A. Exact time of fire drill will be docuemtned on quarterly Fire Drill form. B. Three fire drills will be conducted at various times to include all shift. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place. The Administrator /Designee will audit Fire Drill documentation to ensure that time is documented on Fire Drill form and also that fire drills are conducted on all three shift at various times. The results of audits will be presented to Q/A monthly for six months.	04/20/2011

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	during 4 of the past 4 quarters. This deficient practice affects all occupants. Findings include: Based on a review of Monthly Fire Drill(s) with the maintenance director on 03/21/11 at 1:15 p.m., first shift (7:00 a.m. -3:00 p.m.) fire drills were conducted at 11:30 a.m. (2011), and 9:40 a.m., 11:00 a.m., and 10:30 a.m. in 2010. Documented second shift drills (3:00 p.m.-11:00 p.m.) were conducted at 6:30 p.m. during the first quarter in 2011 and 7:00 p.m. and 7:30 p.m. during the third and fourth quarters of 2010. Third shift (11:00 p.m.-7:00 a.m.) drills were conducted at 4:00 a.m. during the first quarter of 2011 and during the second quarter of 2010. The third quarter drill time was not recorded and it could not be determined if the drill was conducted at any time removed from the 5:30 a.m. drill conducted during the fourth quarter of 2010. The maintenance supervisor agreed at the time of record review, there appeared to be a			

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	pattern to the fire drill training. 3.1-19(b) 3.1-51(c)			

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K0051 SS=F	1. Based on observation and interview, the facility failed to ensure 1 of 3 fire alarm panels in an area not continuously occupied, was provided with automatic smoke detection to ensure notification of a fire at the location before it could be incapacitated by fire. NFPA 72, 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice affects all occupants. Findings include: Based on observation with the maintenance director on 03/18/11 at 12:35 p.m., a fire alarm control panel (FACP) was located in the entry vestibule which was not continuously occupied and was not electrically supervised by a smoke detector. The maintenance director agreed at the time of observation, the panel could be incapacitated by fire before an alarm could be annunciated in the	K0051	K 0051 1. What is the corrective action taken for the resident found to be affected by the deficient practice? A. An automatic smoke detector which supervises the annunciator fire control panel located in the entry vestibule has been ordered. B. Smoke detector connected to the fire alarm system have been properly separated from air supply. C. The air vent by corridor smoke detector near room C has been relocated and is now 38 inches from the smoke detector. D. A sensitivity test will be performed on 144 smoke detectors and will be placed in life safety book. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All smoke detectors will be checked during sensitivity testing will be completed by April 20,2011 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur. A. The maintenance staff will be re-inserviced related to Smoke Detector Regulations and Codes. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place. Contracted services will monitor and report to sensitivity testing every two yesrs	04/20/2011

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	area. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure smoke detectors connected to the fire alarm system in 1 of 6 smoke compartments were properly separated from an air supply. NFPA 72, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and 22 residents on Haven. Findings include: Based on observation with the maintenance director on 03/21/11 between 12:15 p.m. and 4:15 p.m., a corridor smoke detector was located 20 inches an the air vent near room C. The maintenance director confirmed the distance measurement and agreed at the time of observation, the air flow could impede the function of the smoke detector.		and report findings to Maintenance Supervisor who will report findings to Q/A . Maintenace will include monitoring smoke detectors as part of Monthly Preventative maintenace log which wil lbe ongoing. MAintenance Supervisor /Designee will report monthly findings to the Administrator /Designee who will report findings to Q/A ongoing.	

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	3.1-19(b) 3. Based on record review and interview, the facility failed to ensure sensitivity documentation for 144 of 144 smoke detectors was completed, current, and reliable. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods: (1) Calibrated test method.			

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	(2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector." This deficient practice affects all occupants. Findings include: Based on a review of the 08/12/10 Sensitivity Testing Summary Test Results with the maintenance director on 03/21/11 at 2:25 p.m., the report was incomplete. The record noted each smoke			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	detector, its location and the range within which each detector should test, however, the results were recorded as Prior Test and recorded results for 21 smoke detectors as N/A. There was no date for this Prior Test. Current Test results were noted as N/A for all smoke detectors. Reports from previous years were compared with the 08/12/10 report. Test results for smoke detectors at the same locations had different results and were also recorded in an undated Prior Test column. The maintenance director agreed a date for sensitivity testing could not be determined from the records available and it could not be determined if all detectors had been sensitivity tested. He called the contractor immediately. No new information was forthcoming by 5:30 p.m. on 03/21/11. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING _____ B. WING _____	03/21/2011

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K0070 SS=E	Based on observation and interview, the facility failed to provide evidence 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect occupants of the dining room smoke compartment with the capacity for more than 45 residents. Findings include: During observation on 03/21/11 at 12:05 p.m., the maintenance director said the use of space heaters was prohibited in the building and he could not explain why a portable space heater was located in the admissions office. The maintenance director also said at the time of observation, he had no idea the space heater was there and could not provide evidence the heating element would not exceed the 212 F degree limit. He could not provide a written policy for the prohibition or use of space heaters in the facility. 3.1-19(b)	K0070	K 0070 1. What is the corrective action taken for the resident found to be affected by the deficient practice? Space heater was removed immediately. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. A check throughout the facilty revealed no other space heaters were in use. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur. An in-servcie regarding space heater will be presented at the April all staff meeting . 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place. Space Heater observation will be part of monthly preventative maintenace log observation. Log will be reviewed by the Maintenance Supervisor/Designee monthly and findings will be rported to the Administrator /Designee who wil report findings to Q/A ongoing.	04/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K0144 SS=C	Based on record review, observation and interview; the facility failed to ensure documentation for 1 of 1 generators serving as the alternate source of power was complete. NFPA 99, 3-6.3.1.2 requires the emergency system to be arranged so in the event of failure of the normal power source the alternate source of power will automatically connect to the load within 10 seconds. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all occupants. Findings include: Based on review of the weekly and monthly Emergency Generator Test Log with the maintenance	K0144	K 01441. What is the corrective action taken for the resident found to be affected by the deficient practice? Generator Testing is now being documented as starting within 10 seconds . 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All resident have potential to be affected by incorrect docuentation of generator testing 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur. Maintenance supervisor will instruct other maintenace staff on generator testing and documentation 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place. Maintenance Supervisor/Designee will monitor generator log monthly and report findings to Administrator/Designee who will report to Q/A .This monitoring will be ongoing.	04/20/2011

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	director on 03/21/11 at 1:50 p.m., documentation for Switch Time recorded the transfer time as "<25 sec." The maintenance director said he was unaware he should document a transfer within 10 seconds. A demonstration of the generator test by the maintenance director on 03/21/11 at 5:15 p.m., revealed the generator did, in fact, transfer within 10 seconds. 3.1-19(b)			